tral themes of the Acheson report was the need for high quality comprehensive data to improve the capacity to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them.[5]

With increasing computerisation of practices, the actual recording of socioeconomic data should be straightforward. Simple questions relevant to the particular patient could be asked when patients first register and opportunistically at subsequent consultations. New computer codes for the different questions and their responses could easily be produced.

What we are suggesting is not a radical change. It is not about asking intrusive questions, and it would take up very little time. It is simply a systematic and formal way of doing what most clinicians in primary care already do, albeit in a largely opportunistic and possibly rather haphazard way. Recent work from Norway has shown that while the level of general practitioners' knowledge of psychosocial factors varied widely, when such factors were known they often influenced management.[12 13] In practice, older people are often asked if they live alone and about social contacts, and young single mothers are asked about social isolation, their housing situation, and other socioeconomic factors. Such information may not always be recorded and hence may not be put to the greatest use—for example, in generating a referral to a community organisation or to a health visitor.

The government seems to be sincere in its wish to tackle health inequalities. For general practice to play a full part in translating this commitment into improved health for those most in need we will need to record accurate and valid socioeconomic information about our patients.

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Reconstruction of dislocated hips in children with cerebral palsy

Is difficult—and in many cases could be prevented by regular monitoring

Children who suffer from cerebral palsy and do not walk before the age of 5 have a 58% incidence of hip dislocation (44% bilateral, 14% unilateral).[1] Other factors involved in the causation of hip dislocation include four limb cerebral palsy[2] and tightness of the adductor and iliopsoas muscles with concomitant weakness in the abductor muscles at the hip.[3] Whatever the cause, reconstructing the hip in these children involves complex surgery, and parents and their doctors need to be aware that management is not straightforward.

Investigations used to detect dislocation include *x* rays of the pelvis and whole spine; from the former the physician or surgeon can document any progressive tendency of the hip to dislocate by measuring the migration percentage.[4] Such monitoring is important. Associated radiological features of hip dislocation are femoral neck anteversion, valgus femoral neck shaft angles, and acetabular dysplasia.

If a child over the age of 5 has a migration percentage of the hip greater than 40% the time for soft tissue surgery alone has almost certainly passed.[5] Hip reconstruction after dislocation is in effect a salvage procedure. It involves anatomical correction of bony abnormalities in the femur and acetabulum, with shortening of the femur to allow the femoral head to be relocated in the acetabulum. Tethers to the femur, with the inevitably tight pubofemoral ligament and the adductor and psoas muscles, will have to be cut to allow relocation of the femoral head. The acetabulum itself must be cleared of all fibrous, fatty, and ligamentous tissue, and during the operation a decision will need to be made regarding pelvic osteotomy or acetabuloplasty. Chronic damage to the femoral head may be noted during operation and this includes either flattening of the whole head or grooving or pitting of the articular cartilage.

Just as important as the surgery itself is the preoperative and postoperative preparation of the child and parents. A team consisting of an orthopaedic surgeon, a paediatric neurologist, a senior physiotherapist, and a skilled orthotist needs to be involved, and it helps families to meet a member of the ward staff, the play leader, and the clinic coordinator before surgery. The final preoperative assessment, which takes place in a preadmission setting, must ensure that any feeding dif-

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ficulties, muscle spasm, recurrent respiratory infections, and epilepsy are all sufficiently well controlled to allow major surgery to go ahead. It is at this stage that all aspects of discharge arrangements into the community should be addressed.

If there is one issue that perhaps dominates all others for the parents, however, it is worry about how their child will cope with postoperative pain. The effective use of a paediatric pain relief team is absolutely vital. Postoperative muscle spasm can only add to a child's discomfort when he or she is being nursed in, for example, a hip spica, and starting baclofen preoperatively will help. Parents need to be aware, before the operation, of the difficulties associated with managing their child in a plaster spica, the care of a urinary catheter, and the use of suitable incontinence pads.

We know that a painful dislocated hip in young adults is practically untreatable.[6] We also know that, apart from premature degenerative change in the femoral head, scoliosis and pelvic obliquity may occur with a longstanding hip dislocation. Hip reconstruction has, however, a complication rate, with 5% of hips redislocating[2]; the reported incidence of avascular necrosis of bone varies from 0%[7] to 23%[8] of cases. After a successful hip reconstruction quality of life will improve, and patients can sit with greater stability or walk greater distances after a period of rehabilitation. A substantial improvement in hip pain can be expected in most cases. It is now apparent that some children have for years been suffering pain in the hip, unknown to their parents and carers because of communication difficulties.

Hip reconstructive surgery for children with cerebral palsy is a major undertaking—for the children themselves, their parents, and the few centres that offer this operation in the United Kingdom. Monitoring cannot prevent all cases of hip dislocation, but the prime objective of all concerned in managing these children must be to try to prevent progressive asymmetry of the hips and spine.

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Improving the training of SHOs

GMC document doesn't tackle the real difficulty: balancing service and teaching

The General Medical Council has turned its attention to the training of senior house officers. Its new guidance, *The Early Years*, follows *Tomorrow's Doctors* on undergraduate education and *The New Doctor* on the preregistration year, but it lacks the bite of its influential precursors and in its present form is unlikely to provoke similar change.

The document recommends high quality education and training, flexible enough to meet the personal needs and professional aspirations of senior house officers. It emphasises the importance of careers advice, clinical and educational supervision, and provision for welfare. It refers to the particular needs of overseas doctors.

None of this is new.[1 2] Colleges and postgraduate deans have promoted induction programmes, training agreements, structured teaching, consultant appraisal, log books, structured training rotations, flexible training schemes, and (with the BMA) improvements in hours of work. Improvements have occurred in all these aspects, and there is evidence that consultants are taking their role as educators increasingly seriously.[3] Nevertheless, although most senior house officers enjoy their work, others are overwhelmed by the responsibility and find the grade both depressing and demotivating.[4 5]

Part of the problem derives from lack of clarity about the purpose of the grade. Sandwiched between two grades that have undergone educational reform, it has become the workhorse grade. Senior house officers are multiskilled in a way their seniors no longer are and considered experienced enough to be left to cover the hospital at night.[6] Their numbers were expanded to deliver the reduced hours of the new deal,[7] but consequently an increasing proportion of their work is out of hours, when they are less likely to have the benefit of consultant contact or the opportunity to acquire new skills under supervision.[8]

It is this important out of hours service role that works against radical change. For example, the appropriateness of hospital posts in the vocational training of general practitioners has been questioned,[9] but plans to base training in general practice with secondment to hospital for short periods of carefully selected experience would have consequences for maintaining out of hours rotas in the hospital service[10] and have not been implemented. Indeed, service demands are so great that recruitment of overseas doctors has increased to meet the expansion of the grade. Non-UK graduates now make up over 30% of all senior house officers, and over 50% in shortage specialties, such as psychiatry, or those with poor prospects of promotion to specialist registrar grade, such as obstetrics and gynaecology.

The GMC document recommends that these doctors should be provided with clear, up to date and comprehensive information about working and training opportunities in the United Kingdom, the types of registration available to them, and details of the Profes-

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